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from the desk of ***Philip R. Endress, LCSW, ACSW***
Commissioner of Mental Health

TO: Mental Disability Agencies - Children & Adults

DATE: Philip R. Endress, LCSW, ACSW

RE: Request for Proposals:
Transition Assistance & Care Coordination Initiative

DATE: August 23, 2006

The Erie County Department of Mental Health is accepting proposals to develop and provide a comprehensive Transition Assistance and Care Coordination (TACC) Initiative in accordance with the attached Program Design. A total of $400,000 is available to support two Care Coordinator positions and an array of individualized services necessary to assist older adolescents and young adults ages 16-21, with exception up to age 23, with significant emotional/behavioral disorders that constitute a barrier to their successful transition to adulthood, not patient-hood, in one or more of four transition domains: vocational, educational, housing and community life functioning.

Attached is a description of the TACC Program Design, the TACC Request for Proposals and a list of Major Criteria for Evaluating Proposals for Funding. Preference will be given to applications that describe and quantify prior and/or current successful experience working with the transition target population, experience working with individuals with emotional/behavioral disorders, applicants with past successful vocational experience placing young adults in non-traditional, career focused jobs, and applicants who have a successful history and have demonstrated a rapid start-up and implementation of other new initiatives in the past. A new feature of this Request for Proposals, Attachment I, asks applicants to quantify their past successes in achieving transition outcomes in other agency programs. This represents the Department's increasing reliance upon data-driven program planning and evaluation.

Completed applications must be received by the close of day, **Tuesday, September 12, 2006**, to the Erie County Department of Mental Health, 95 Franklin Street, Room 1237, Buffalo, New York 14202. Applications received after this time will not be considered for award. In the interim, should you have any questions regarding this RFP, please contact John Grieco, Coordinator of Mental Disability Services, at 858-6381.

Dept. of Purchase REF.#06040VF

TRANSITION ASSISTANCE & CARE COORDINATION

PROGRAM DESIGN

Introduction

The transition from adolescence to adulthood is a challenging process under the best of circumstances. Successful transition is marked by the achievement of traditional milestones such as graduating from school, entering and completing college, forming close relationships, effectively participating in the community, securing a first job, establishing a career, living away from family, getting married and starting a family. Young adults with psychiatric/behavioral disorders want the same 'normal' experience of growing up as their non-disabled peers: completing school, finding a job, and making friends. However, they often lack the skills, supports and opportunities to do so; and they too often do not attain these major markers of adulthood. Too often, they experience the highest rate of school drop-out, poor post-secondary outcomes in employment and independent living, and have higher rates of arrests and incarceration. They experience unplanned pregnancies, abuse drugs and alcohol, homelessness and unemployment. Young people with emotional/behavioral challenges 'age out' of children's mental health, education, juvenile justice, social and youth systems of care and lose numerous services and supports they had been receiving. Yet, they are too often either not eligible or appropriate for adult systems of care. There are a significant number of young adults in secondary education with emotional challenges who are undiagnosed. Too often, transition planning in schools does not occur, and these young people drop off the radar screen after turning 18 and/or leaving school, and end up in a marginal existence of homelessness, unemployment, substance abuse, and crime, and on public assistance, and this does not allow them to fully achieve their maximum potential as productive citizens of the community. This can result in the eventual emergence of later serious mental illness, presenting even further significant barriers to successful functioning in society. Yet, these young adults have similar goals and interest as older adults: a job or career; increasing independence and competency; continuing education; social/recreational opportunities; and living successfully in the community.

This 'transition' population of adolescents and young adults with emotional/behavioral challenges also presents unique administrative challenges to our systems of care such as age limitations and other restrictive eligibility criteria, different terminology and definitions, and systems of care designed to serve either younger children or older adults. Further complicating the issue, transitioning youth fall into different sub-categories, including those with mood disorders or substance abuse, those with emerging chronic thought disorders and those with schizophrenia or other major disorders, each with different needs and requiring a different approach. Too often their chronological age does not correspond to the developmental age and the special issues facing adolescents and young adults. A program supported by blended funding can provide the flexibility necessary to circumvent these rigid eligibility requirements of competing systems of care.

Early and effective intervention can lessen the severity or later onset of mental illness, prevent disability and improve recovery. Improving young people's ability to make good decisions and

skills to cope with life events can contribute to their level of self-esteem and emotional stability. Innovative mental health services for the transition population are characterized by earlier intervention that reduce delays in treatment, provide age appropriate employment, independent living, education and social skill development, and by employing staff with a developmental background and successful prior experience engaging and working with young adults.

Evidence-based practices describe transition services that are designed to assist young adults in making successful transition into adulthood in three broad areas: economic self-sufficiency, physical and mental well being, and community engagement, with the developmental outcomes of becoming autonomous, educated, productive and connected. Other research in the area identifies four life domains of transition: employment/career, education, living situation and community life functioning. Service delivery guidelines of practice typically describe engaging young people through developing relationships, establishing individualized strength-based and age-appropriate services and supports, reinforcing personal choice and responsibility, ensuring a safety-net of support, increasing young people's competencies and skills, and involving young people and families as full partners in service planning and delivery.

Work represents one of the core components of successful transition to adulthood. A Substance Abuse & Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) 5-year, multi-site study recently reported significant findings regarding barriers to work and evidence-based practices to assist and support individuals with mental disabilities in finding and keeping jobs. Significant barriers to work included recent psychiatric hospitalization, self-rated poor functioning and negative psychiatric symptoms, co-occurring substance abuse disorders, stigma, potential loss of entitlement benefits and a lack of job training. Common elements of successful vocational rehabilitation services included: integration of mental health and vocational services, support in entering or re-entering the workforce as soon as possible, an emphasis on individual preferences, practical assistance in finding jobs, ongoing assessment and support, and encouragement of vocational goals. This study found that having any work history in the previous 5 years roughly tripled individuals' chances of getting a job, while factors that decreased the likelihood for success included increasing age and lack of a high school education. A full report on the 'Employment Intervention Demonstration Program' (EIDP) can be found at www.samhsa.gov.

PROGRAM DESIGN

The TACC was developed and designed based upon a review of the research literature on transition, and with the input and guidance of a planning committee that included representation from the Buffalo Public Schools Division of Special Education, the Office of Vocational Services for Individuals with Disabilities, service providers, youth coordinators, youth advocates, parent advocates, Erie Community College and Erie County.

The TACC service model will consist of Care Coordination, coupled with individualized services that are purchased through a vendor network and 'wrapped around' each individual, based upon their unique needs, interests, choices and goals. In this model, the type and extent of services that are provided to each young adult are determined and driven by the individuals' unique needs and interests, as opposed to a pre-defined program staffing pattern. The TACC

will develop and provide guidance, supports and assistance to young adults in developing more effective life skills that lead to better choices and successful functioning in the community: getting a degree, a job, stable housing, and successful and independent functioning in the community. This leads to young adults assuming a greater responsibility for choices and actions, achieving a higher level of dignity and self-respect, along with the right to take risks and to fail as well as succeed, and developing a more positive self-image and a higher level of self-confidence.

A. The TACC will serve the following **Target Population**:

Youth age typically between 16-21, and on an exception basis, up to age 23, with serious behavioral and emotional issues, or who may be projected to develop an emerging serious behavioral/mental disorder after age 17 for which the children or adult mental health systems are determined not appropriate. The three (3) prioritized sub-populations are:

a) Individuals who did not graduate from high school, dropped out of school, and who are now not successful in one (1) or more of the four (4) transition domains.
b) Individuals who graduated from high school but are now not successful in one (1) or more of the four (4) transition domains.
c) Individuals who are still in school and are at high risk to not graduate, drop out and/or be unsuccessful in one (1) or more of the four (4) transition domains.

Within each of the 3 prioritized sub-populations, individuals must meet the following eligibility criteria:

- **Significant current emotional/behavioral challenges that create barriers to achieving certain key developmental milestones, and**
- **Who demonstrate a need for services to address a deficiency in at least one of the following transition domains:**
    1. **Secondary or post-secondary educational and/or training** (***no diploma or GED; not enrolled in any post-secondary education, training or trade school)***
    2. **Employment** *(unemployed; no or poor work history)*
    3. **Independent Living** *(homeless or at-risk; in crisis housing, detention, in other residential placement)*
    4. **Community Life Functioning: Independence & Integration** *(significant deficits in social, health, mental health, substance abuse, mobility, community engagement, independent living skills, self-determination/juvenile justice, communication or interpersonal relationships that are a barrier to successful transition)*

And

Not at imminent risk for psychiatric hospitalization or inpatient residential treatment *(based upon current behavior; risk-assessment);*

And

There exists reasonable confidence that the individual can be expected to achieve the goal in one of their identified goal areas through the services of the Transition Initiative within a reasonable time frame *(rating at admission)*

And

Not eligible or appropriate for children's (Family Voices Network) or adult mental heath service *(rating at admission)*

And

There exists little or no current linkage and support to needed natural supports and community resources *(documentation at admission)*

The TACC is expected to serve individuals with a wide range of types of transition service needs and intensities. No otherwise eligible individual will be excluded due to the severity of their behaviors or symptoms, co-occurring substance abuse or other disorders, lack of work history or the presence of juvenile justice history or involvement. Rather, eligibility determinations will be based upon the questions: does the individual demonstrate significant emotional/behavioral challenges and functional deficits that constitute a major barrier to successful transition to adulthood in at least one of four transition domains; is the individual currently without needed supports to achieve successful transition; and can the individual benefit and succeed with the supports and services available through TACC.

B. The TACC will incorporate and operationalize the following **Principles and Values**:

a) Engage young people through partnership and relationship development, person-centered-planning and a focus on their strengths, natural support systems and their future.
b) Provide individualized services and supports to be accessible, coordinated, age-appropriate, built upon strengths and designed to enable young people to pursue and achieve their transition goals.
c) Nurture and develop personal choice and responsibility.
d) Enhance young persons' skills and competencies to assist them in achieving greater self-sufficiency and independence.

C. The TACC **Services** will reflect the following standards:

a) Provide effective strategies to **successfully engage** young adults in services. This means employing qualified staff and reaching out and providing services at times and places where the individual is most accessible, and in an age-relevant way. Success in engaging young adults is critical to program success in helping young adults achieve their transition milestones.

b) **Develop individualized service plans, based upon the process of person-centered-planning and a comprehensive, strength-based assessment,** that recognize individuals' cultural and familial values and incorporate individuals' natural supports in the community. A unique focus of the TACC is on identifying incentives and rewards unique and important to each young adult (carrot) instead of imposing penalties (stick). The TACC will also provide structured opportunities that bring success, providing a positive experience and reducing the fear and long history of failure that young people with emotional/behavioral challenges often experience. Interventions will promote a sense of hope and maximize the likelihood for success and competence. Starting with small, incremental experiences that are successful and rewarding will contribute to changing the young adult's personal sense of competence, self-worth and continuing motivation to succeed.

c) Care Coordinators and vendor staff and all others identified and participating in the individual's service plan will work as a **team**, with regular, scheduled service planning, implementation and evaluation meetings to monitor and manage services to enrolled young adults. The right balance will be struck between providing, helping, and promoting self-responsibility and accountability for behaviors. Individuals' natural supports reflected in the service plan will participate on the team.

d) Care Coordinators and vendor services staff will have **experience and possess the unique skills necessary to be effective in working with older adolescents and young adults**, and have special skills and knowledge of this developmental age range, knowledge of emotional/behavioral and mental health disorders, and experience and knowledge of effective engagement and intervention strategies for this developmental age range. Services will be mobile, and provided when and where needed: in the community, at home, on-the-job, in school, and during the day, evening, weekdays, and weekends. Services will be recovery and rehabilitative, and focus on teaching skills necessary to succeed in the community.

e) The primary service focus of the TACC from day one is in coordinating services and in identifying, developing, nurturing, strengthening and i**ntegrating enrollees' natural supports** into their services and service plans. Initial assessments will include an identification of individuals' existing natural supports and implementation of strategies to develop and strengthen the natural supports that will remain in the individual's life during and following discharge from TACC. Discharge plans that reflect the (re-)integration of individuals back into the community with natural supports will begin at admission to the TACC.

f) **Implement a comprehensive, holistic** approach that will address four primary domains of a young adult's life: education, vocational, housing and community life functioning. The TACC focuses on skills development and community integration, based upon the needs and interests of young adults that are relevant to their lives. The focus is on teaching and nurturing the development of individuals' own skills so they will ultimately achieve and maintain successful transition to adulthood in the community without the formal TACC, but rather with their own natural supports and other community resources.

The TACC will address individuals' low self-esteem and negative self-perceptions, and instead seek to empower young people to make choices and decisions about their lives and to take responsibility for those choices. At the same time, opportunities for new areas of interest and learning will be promoted and encouraged. The TACC services will be provided in an accessible, safe and comfortable environment to each young adult, away from the stigma and embarrassment often associated with mental health services. Services and service strategies will be age-appropriate and relevant to successfully engage young adults.

Needed mental health services will also be closely coordinated and integrated with the vocational services provided through the TACC. The coordination and integration of these two service elements has been shown to be essential to achieving successful vocational outcomes for individuals with mental disabilities, in assessment, symptom and medication management, and treatment modalities.

g) **Provide age-appropriate** set of services designed to assist and support young adults ages 16-21, up to age 23 by exception, with emotional/behavioral challenges in transitioning from children's systems of care to successful adulthood in the community.

h) **Provide services that are culturally competent** in order to work effectively with the multi-cultural young adults and their families enrolled in this program. This means understanding and respecting the values and norms of the diverse cultures represented, and in providing services in a manner, language, time, and place that is responsive to the unique cultures of enrolled young adults.

i) Instill **high expectations and goals** for post-secondary education and employment, which are essential for youth reaching and achieving their transition goals. This standard needs to be established at admission and reinforced throughout the transition process. Promoting self-sufficiency and goals of employment among youth with disabilities is important in instituting a culture change in the disability employment field that begins to target non-traditional employment goals within a strong career focus.

j) The TACC represents a demonstration project that seeks to achieve **broader system change**.

A system goal of the TACC is to work with, assist and support the current adult mental health system of care to increase their level of knowledge, expertise and effectiveness in working with young adults who have more significant mental disorders and for whom the adult mental health system would be appropriate. This would take the form of new services, improved training, enhanced staff education and experience qualifications, and the implementation of evidence-based and other practical service strategies in those traditional mental health programs.

D) The TACC will provide the following **Services:**

a) Care Coordination

Each transitioning individual served will be assigned a care coordinator, who, in partnership with the individual, will complete a strength-based comprehensive transitional assessment (CTA). The determination of eligibility and the assessment process will utilize quantifiable measurement tools. The CTA will include a psychosocial history, and identify the individual's current status, abilities, interests and future goals and the services and supports necessary to achieve a successful transition to adulthood in four transition domains: education, employment, housing and community life functioning. Individuals without a degree will be encouraged and supported to complete their secondary education. Any supports necessary to stabilize or establish the individual's living situation will be identified and then provided directly or accessed through available community resources. The TACC Care Coordinator will have a strong knowledge and experience in vocational services. The CTA will identify the vocational supports and services necessary to address this transition barrier and assist the individual in achieving his/her vocational goal. An initial vocational assessment will include the individual's work history, work and work-related skills, interests and short and long-term vocational goals, and their supports, services, education and training needs necessary to finding, securing and keeping a job. The individual's interests and preferences will be of central importance in developing a vocational plan. Needed vocational services will then be provided rapidly either directly by TACC or through referral to an appropriate community resource, such as VESID. Community life functioning includes developing social relationships and peer networks, health, mental health, substance abuse, mobility, community engagement, independent living skills, self-determination, communication and interpersonal relationships. Other miscellaneous areas to be assessed in the CTA include daily living skills, money management, personal/community safety, legal, cultural and spiritual. The CTA will identify the individual's current network of resource and supports. The results of the various components of the CTA will be integrated into a comprehensive transition plan.

The TACC Care Coordinator, in equal partnership with the individual, will develop an individualized **comprehensive transition plan** (CTP). The CTP will reflect the individual's current status, his/her long-range transition goals, and the short-term objectives to achieve those goals in each of the four primary transition domains. Objectives must specify the activities and responsible parties involved, and a projected date of completion. The CTP must be signed by all parties participating in the Plan. The CTP will build upon the individuals' current strengths, support networks and resources. The CTP Care Coordinator will oversee, monitor, coordinate and integrate the CTP within TACC as well as across the other systems of care that the individual is involved with or needs, including mental health, social services, youth services, juvenile/criminal justice, and substance abuse and housing. The TACC will work closely with staff of other programs that the young adults are enrolled in, in order to assure coordination of services. The CTP goals and objectives will be measurable and monitored. The TACC services will not only provide skill-based acquisition training, but also opportunities to practice and try out those newly acquired skills in a real-life setting that maximizes the likelihood

for success. The TACC Care Coordinator will also provide backup on-call 24/7 access for crisis intervention.

b) Individualized Services

Individualized services will be provided primarily on a one-to-one basis, based upon person-centered-planning principles, although some services may be provided through a group process, using evidence-based 6-8 week modular-based training curriculum, if all individuals share the same need, and a group setting is appropriate and viable. This initiative will employ a Care Coordination broker service delivery model so that transition services are driven by the needs of the enrolled young adults and not by a pre-existing staffing model.

Examples of individualized services in a CTP include: post-secondary education/training, vocational assessment, career exploration, work readiness, intensive job training, job placement, job follow-along services, classroom aide, crisis and permanent housing, peer support, social/recreational skills, mental health treatment, medication education and management, substance abuse treatment, life skills training, mobility training, independent living skills, community safety, personal, health/hygiene/sexual education, mentoring, family supports, self-advocacy skills, legal/financial supports, benefits and financial aid counseling, anger management, decision making skills, cultural activities, spiritual activities, legal services and supports, transportation, work incentive opportunities and asset development.

The TACC will refer, link, access and/or purchase and provide individualized services identified on the CTP through a combination of one or more of three sources in order of precedence: a) utilization of the individual's natural supports, b) linkage and referral to existing available generic organizations that provide needed individualized services, such as VESID, the Vocational One-Stop Centers, ECDSS Independent Living, local housing shelters, school districts and private agencies, c) and/or direct reimbursement through a formal approved vendor network.

1) Natural Supports: These include family members, relatives, neighbors, friends, and other significant individuals, groups and organizations in the young adult's life. It is expected that individuals' natural supports will be maximized and reflected in the initial assessment and in enrollees' service plans from day one. The integration of natural supports will play a key role in providing assistance and support to individuals during and after discharge from TACC.

2) Generic Organizations: It is also expected that individualized services will be secured from agencies and organizations with designated responsibility for providing educational, vocational, housing, mental health and substance abuse services. These include BOCES, school districts, Vocational and Educational Services for Individuals with Disabilities (VESID), Erie County Department of Social Services, crisis and transitional housing programs and centers, mental health clinics, housing programs and substance abuse programs.

3) Vendor Network: This Transition Initiative will develop and designate a specialized Vendor Network that meets specific education, training and experience qualifications necessary for working effectively with young adults with emotional/behavioral disorders. The TACC will work with the ECDMH to develop and designate a TACC Vendor Network comprised of both new providers and qualified existing providers within the Family Voices and Vocational Networks of Vendors to access needed individualized services. It is expected that the Transition Initiative agency will secure needed individualized services from a range of approved vendors within the designated network, and not rely upon or exclusively utilize their own agency-operated vendor services. Designated vendor agencies will have demonstrated a capacity for providing individualized services that are readily available when needed, flexible and responsive, culturally diverse, and innovative and creative. The vocational vendor agencies will have demonstrated a capacity for developing and placing individuals in jobs that are non-traditional for people with mental disabilities, and that represent the interests and highest abilities of young adults, and provide a real opportunity to earn a good wage, and with a focus toward career advancement. These individual services will be provided based upon an individual's needs, the availability of and access to service and any case-specific considerations. Individuals enrolled in TACC may also be co-enrolled and receiving services provided by other community-based programs providing services needed and reflected on individual service plans.

During the demonstration period, individualized vocational services will be purchased directly by TACC from a network of new providers that are dedicated to the transition population. This is to accomplish several objectives: to assure that these critical vocational services are sufficiently and readily available to individuals when needed; to provide a capacity to serve individuals awaiting and/or not otherwise eligible for other vocational sponsored systems of care; to provide services that are of sufficient duration to achieve vocational transition goals; and to develop the special expertise and ensure that the vocational services are provided by staff that possess the unique skills, experience and qualities necessary to be effective with the unique young adult transition population. Lessons learned during the demonstration project can then be applied in the future to affect such changes within the broader vocational Vendor Network in order to enhance their effectiveness with this target population, and as a strategy to then expand the TACC in the future by accessing VESID, OMH and OMRDD resources for some of these vocational services. The demonstration period will provide the opportunity to identify the extent of need and support for these offices to plan and budget for additional resources necessary to provide vocational services to young adults enrolled in the TACC in the future. Following the demonstration period, TACC will continue to purchase vocational services directly for enrolled individuals awaiting a determination of eligibility, or determined not eligible or no longer eligible for vocational services through VESID, OMH or OMRDD.

The TACC will adhere to Drake's evidence-based supported employment model for those individuals needing this level of vocational support. Caseload size is limited to 15;

vocational services are provided by vocational specialists; vocational specialists, other service providers and mental health treatment professionals are part of the service team, coordinated by a Care Coordinator; there are no eligibility exclusions due to severity of behaviors, lack of job readiness, substance abuse or dual diagnosis. In this model, vocational assessment is ongoing, and occurs in community work settings rather than through written testing or observations within a sheltered or enclave setting. Such environmental assessments will be based upon reasonable accommodations. Job placements may be considered initial (a first job that serves to develop and strengthen work tolerance and teach basic work-related behaviors while exploring vocational interests), replacement (where job change occurs naturally on the path of vocational growth and development) and advancement within a career. The search for a needed competitive job will occur rapidly following admission to the program; generally between 1 and 6 months following enrollment. Vocational goals and activities are based upon each individual's unique preferences, needs, abilities and interests rather than job availability. A focus of the vocational services is to actively seek and pursue a wide range of diverse work options that are competitive and permanent in status and at different times and different settings for individuals seeking a job. Once stabilized on a job, unlimited, flexible and individualized follow-along supports will be provided to the employer and individual for guidance, information, crisis intervention, job counseling, support groups and networking support. These services are provided in the individual's natural environment in the community in which she/he lives and works. Individuals who withdraw prematurely from vocational services are contacted and actively followed up to assess the reasons and conditions for self-termination and to provide the supports and encouragement designed to re-engage the individual in vocational services as soon as possible. Initially, during start-up and early enrollment, the majority of vocational services will include vocational assessment, job training and placement. As individuals progress through the vocational continuum over time, an increasing number of individuals will require follow-along vocational services.

Referrals to TACC can come directly from individuals or families, the community at large or other children's and adult's systems of care. The TACC will especially target and implement aggressive outreach, communication and coordination with high-target referral sources that include crisis housing and homeless programs (Compass House, Franciscan Center, Little Portions), Family Court and other juvenile justice programs such as Early Intervention and PINS Diversion, Renaissance House, and School District Committees on Special Education.

E) The TACC will design and implement a **Program Evaluation.**

The TACC will develop a multi-faceted program evaluation component. Outcomes will focus on areas of success within four domains that represent successful transition to effective adult functioning in the community: education, vocation, housing and community-life functioning. In addition to measuring achievement of contracted outcomes, the program evaluation will look at other supplemental performance data to be determined, but that will minimally include quality standards (e.g. length of time between referral and enrollment); outcome subset data (e.g. type of integrated employment

achieved); utilization (enrollment and services); and other measures as needed. This supplemental data protocol will be designed to measure program development, evaluate program effectiveness and answer pre-defined questions concerning program design during the first full year of operation (2007). Program Evaluation data will be reviewed by the Advisory Committee and used to both assess achievement and strengthen service delivery and outcomes in the future.

F. The TACC will establish an **Advisory Council.**

The TACC will have an Advisory Council to provide support, information, oversight and guidance in program development, performance, utilization and integration into the larger childrens' systems of care in Erie County. Membership will include all major community stakeholders in a transition system of care: school districts, youth and parent advocates, service agencies, schools of higher-education and service providers. The Advisory Committee operates as a learning community where TACC services, utilization and outcome data are periodically reviewed and discussed. This process represents a partnership learning experience where we will learn and adjust as the TACC develops and evolves over time. The first full year of operation is seen as a demonstration period where a defined set questions and of performance and outcome data necessary to evaluate and modify and refine the program in the future is collected and analyzed. Such questions include: ideal caseload size, what works, most effective individualized services, the make-up of a specialized Vendor Network, and average length-of-stay. The Transition agency will develop and implement a process for the collection and reporting of outcome and other to-be-defined measures of program performance and evaluation.

A subset of the Advisory Committee will meet bi-monthly and provide a level-2 Utilization Review function for a standardized review of admissions, service delivery and discharge, and long-term follow-up in order to assist and assure that the Transition Initiative is serving the intended target population, establishing Transition Service Plans and adhering to established discharge criteria.

G. The TACC will have the following **Capacity/Utilization:**

Each Care Coordinator will have a maximum caseload of 15. This initiative will support two (2) Care Coordinators providing a total program capacity at any one time of 30, although more than 30 individuals may be served during a contract year as a result of actual length-of-stay experience and admission/discharge trends.

H. The TACC **Annual Budget**

A total of $400,000 is available for the TACC to support the following costs:

Staffing*:	
Care Coordinators ($55,000-2 FTE)	$110,000
Supervisor ($65,000/.25 FTE)	$16,250
Support Staff ($30,000/.25FTE)	$7,500
Care Manager	$7,500
Sub-Total	$141,250
Individualized Services:	
Intensive Job Coaching	$80,000
Follow-Along	$50,000
Other services	$90,000
Flexible dollars	$27,750
Direct administrative fee**	$11,000
Sub-total	$258,750
Total	$400,000

* Individual staffing lines may vary from the above, but the total staffing budget must be within $141,250. Includes salaries, fringe benefits, OTPS, property and agency a &oh costs.

** Direct administrative fee for individualized services: 5% of budgeted individualized services and reported at 5% of actual individualized service costs, or a maximum of $11,000, whichever is lower.

TRANSITION ASSISTANCE & CARE COORDINATION

REQUEST FOR PROPOSALS

Please answer all questions below in response to the attached Transition Assistance & Care Coordination Program Design. Particular preference will be given to applicants that have had prior experience working with the transition target population, experience working with individuals with emotional/behavioral disorders, and applicants that can demonstrate past successful vocational experience placing young adults in non-traditional, career focused jobs.

Applicant:

1. Agency Name:
2. Agency Address:
3. Contact Person:
    a. Name:
    b. Telephone Number:
    c. Fax Number:
    d. Email Address:

1. Where will the TACC be housed in your organization? A .25 FTE Supervisor is supported in the fiscal model. Who will this supervisor be, and what is his/her experience working with young adults?

2. Identify and quantify on Attachment 1 your agency's successes in achieving transition outcomes for young adults enrolled in other agency programs.

3. How long will it take you to implement this new initiative? Give a timeline from the date of notice of award, to the hiring of staff, to the date of readiness for a first admission and enrollment. Please describe potential barriers you anticipate toward achieving your proposed startup schedule and how you will address those barriers. Identify two recent new initiatives your agency developed and give the actual timelines for implementation of those initiatives.

Program Model:

1. Describe your agency's experience in serving young adults who meet the profile of the target population. Be specific regarding the programs and services through which you gained this experience. What unique challenges did you experience in engaging and working with young adults with disabilities and what strategies did you implement to address those unique challenges? Be specific and give examples.

2. Describe your agency's experience in implementing a Care Coordination model. Identify the program(s), target population and number of years of experience in Care Coordination. What lessons have you learned that you believe would be helpful,

instructive or beneficial to implementing the TACC initiative? What concerns might you have regarding implementing the TACC model?

3. What experience does your agency have in developing strength-based assessments and individualized service plans based upon the values of person-centered-planning? Give examples.

4. What will be the education, work experience qualifications and the qualities you believe are critical and necessary for working effectively with young adults and that you will establish and require for hiring staff?

5. What will be the minimum qualification requirements for the TACC Care Coordinators? Given the strong vocational focus of TACC in providing initial vocational assessments, service planning, and referral, what special vocational requirements will you require for Care Coordinators? Describe your experience and your ideas for implementing and assuring that higher expectations and goals are promoted in young adults' transition plans, particularly in the vocational domain.

6. What experience have you had working with school districts? Please specify the schools, the services provided and the student target population involved. How did you measure outcome success, and what successes did you have? What challenges did you encounter working with school districts and what strategies did you employ to address them?

7. What challenges, if any, do you perceive with the establishment and identification of a preferred vendor network of individualized service providers that are uniquely qualified to work with the TACC target population? What strategies and plans would you develop and implement to establish such a network? From what agencies might you secure needed individualized services in Erie County?

Case Example:

1. Provide a profile of a young adult who is eligible for this initiative. Include his/her status against the priority subpopulations, functional status, strengths and service needs. Describe the assessment process, service plan development, establishment of transition goals and how the young person's natural supports are identified and integrated into service delivery at admission, through enrollment and at discharge. Identify what tools and instruments will be used in each of these stages of service planning, delivery and monitoring.

Budget:

1. Provide an itemized operating budget for your TACC proposal. Identify costs for salaries, fringe benefits, itemized other-than-personal services, property, equipment and agency administrative and overhead, for both the 2006 contract year (including identified one-time start-up costs) and an annualized 2007 budget period.

ATTACHMENT 1

For those agency programs that serve or served a transition population of young adults ages 16-21 with emotional/behavioral disorders, identify the number of young adults who had a transition outcome and the percentage of those young adults who achieved that outcome, for each applicable outcome in the four transition domains below. It is recognized that no agency or program addresses all of the transition outcomes below. Please insert any data you have for any of the transition outcomes below for which you have data. Please also attach a brief description of how you measured your outcomes. Describe and add any transition outcomes other than those below that your program targeted and tracked.

SCHOOL DOMAIN

	Transition Outcome	# With Outcome	% Achieved Outcome
1	Remained in school during enrollment and at discharge		
2	Improved school attendance		
3	Improved average grade academic performance		
4	Graduated from school with a degree		
5	Enrolled in post-secondary education or training		
6	Completed post-secondary education or training		

VOCATIONAL DOMAIN

	Transition Outcome	# With Outcome	% Achieved Outcome
1	Completed vocational assessment to identify job/career interests		
2	Completed job readiness training		
3	Successful placement in a job		
4	Successful placement in a career		
5	Completed a job placement within 90 days of enrollment		
6	Kept a job for 90 days following placement		
7	Earned minimum wage		

HOUSING DOMAIN

	Transition Outcome	# With Outcome	% Achieved Outcome
1	Ended homelessness; placed in temporary housing		
2	Ended homelessness; placed in permanent housing		
3	Stabilized and maintained permanent housing placement at least 6 months		
4			

ATTACHMENT 1 (Cont.)

COMMUNITY LIFE FUNCTIONING

		Transition Outcome	# With Outcome	% Achieved Outcome
1	Social/peer	Established a personal social network		
		Reduced social isolation		
		Increased # of social activities w/others		
		Established relationships with peers		
2	Mental Health	Improved attendance at mental health program		
		Demonstrated improvement in mental health symptoms		
		Improved mental health status		
		Demonstrated ability to identify and express feelings		
3	Substance Abuse	Improved attendance at SA programs Improved SA status		
		Improved SA status		
4	Community Engagement	Increased participation in community groups, activities and volunteer opportunities		
		Demonstrated knowledge of civic responsibilities		
		Increased participation in cultural or spiritual activities		
5	Health	Improved nutritional status		
		Demonstrated healthy/safe behavior in community		
		Demonstrated safe-sex knowledge/behavior		
		Improved skills in self-care		
6	Daily Life Skills	Demonstrated independent mobility skills		
		Able to travel independently in the community		
		Demonstrated skill to manage money		
		Demonstrated knowledge/skills in community safety		
		Ability to adequately maintain living space		
7	Self-Determination	Demonstrated ability to problem solve		
		Improved ability to make good judgments		
		Demonstrated ability to set goals/make plans		
		Demonstrated ability to advocate for self		
		Demonstrated ability to acquire information or resources in the community		

MAJOR CRITERIA FOR EVALUATING PROPOSALS FOR FUNDING

Agency:

1. Has the agency demonstrated the ability to develop and implement new programs successfully and timely in the past? Is the agency's proposed start-up of the TACC timely?
2. Does the agency have experience with the target population and with providing non-traditional, career-focused job placements?
3. What has been the agency's prior experience and success in achieving successful transition outcomes for young adults in other agency programs (Attachment 1)?
4. Is the TACC housed within the organization to receive the necessary program supervision and oversight?

Program Design:

1. Is the proposal consistent with the TACC Program Design?
2. Does the application describe and include services and processes that address all four transition domains?
3. Is the application clear regarding the transition target population?
4. Are the proposal qualifications for Care Coordinators sufficient and appropriate for their functions within TACC?
5. Does the application describe the coordination between TACC and school districts?
6. Does the proposed program describe and reflect the desired principles and values of TACC, including person-centered planning, individualized, natural supports, strength-based service planning and culturally competent services?
7. Does the applicant have experience with the Care Coordination model, and does the application describe the provision of individualized services through a specialized Vendor Network?
8. Does the proposal include a Program Evaluation design and a representative Advisory Committee?

Budget:

1. Is the budget clear, complete, with rationale for expenses and within the available funding?
2. Is the budget cost-effective?
3. How does the budget compare to similar Care Coordination programs?